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ABSTRACT

With the development of tests to detect infection with Human Immunodeficiency Virus (HIV), it has become possible to determine its prevalence and to monitor trends in populations. Such information is valuable in designing, implementing, and monitoring public health programs for the prevention and control of HIV and the Acquired Immune Deficiency Syndrome (AIDS). Before the screening of any population for HIV infection, a variety of logistic, laboratory, operational, legal, and ethical issues must be carefully considered. The design of a methodology for HIV surveillance should attempt to maximize the likelihood of obtaining accurate and useful epidemiological information about the distribution of HIV infection in the community concerned while minimizing the likelihood of adverse consequences. Each surveillance method has its limitations. Over the last few years, however, epidemiologists have increasingly advocated unlinked anonymous screening as an accurate and cost-effective method for public health surveillance of HIV infection. The main objective of the European Meeting on HIV Seropositivity and AIDS Prevention and Control was to determine how and when surveys of HIV seropositivity could be used, by reviewing their epidemiological, psychosocial, ethical and legal aspects. Such surveys would be integral components of national AIDS prevention and control programs. This report includes discussion and recommendations on the methods, problems, and usefulness of testing, on ethical and practical issues of HIV surveillance, and the scope and characteristics of effective national programs. (LLL)

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HIV SEROPOSITIVITY AND AIDS PREVENTION AND CONTROL

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Report on a WHO meeting

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Introduction

The European Meeting on HIV Seropositivity and AIDS Prevention and Control was held in Moscow from 14 to 17 March 1989. The Meeting was hosted jointly by the Government of the USSR and the WHO Regional Office for Europe. It was the third in a series of European meetings held to stimulate an intersectoral public health approach to prevent the further spread of human immunodeficiency virus (HIV) infection. The 87 participants included 20 temporary advisers and representatives of 28 European Member States, the Council of Europe, the Commission of the European Communities, the WHO Regional Office for Europe and the Global Programme on AIDS in WHO headquarters. There were about 60 observers from the USSR.

The participants were welcomed by Professor E.I. Chazov, Minister of Health of the USSR; Dr J. Mann, Director of the WHO Global Programme on AIDS; Professor V.I. Pokrovsky, President of the Academy of Medical Sciences and Director of the Central Institute of Epidemiology, Moscow, and Dr J.E. Asvall, WHO Regional Director for Europe. The Chairman of the Meeting was Professor L.O. Kallings. Professors V.I. Pokrovsky and Laura Ayres served as Vice-Chairmen, and Dr A.M. George was the Rapporteur. Dr A. Gromyko acted as Secretary. The list of working papers comprises Annex 1, and the participants are listed in Annex 2.

Scope and purpose

With the development of tests to detect infection with HIV, it has become possible to determine its prevalence and to monitor trends in populations. Such information is valuable in designing, implementing and monitoring public health programmes for the prevention and control of HIV and the acquired immunodeficiency syndrome (AIDS).

Before the screening of any population for HIV infection, a variety of logistic, laboratory, operational, legal and ethical issues must be carefully considered. The design of a methodology for HIV surveillance should attempt to maximize the likelihood of obtaining accurate and useful epidemiological information about the distribution of HIV infection in the community concerned while minimizing the likelihood of adverse consequences to individuals or the community from the screening. Each surveillance method has its limitations. Over the last few years, however, epidemiologists have increasingly advocated unlinked anonymous screening as an accurate and cost-effective method for public health surveillance of HIV infection.

The main objective of the European Meeting on HIV Seropositivity and AIDS Prevention and Control was to determine how and when surveys of HIV seropositivity could be used, by reviewing their epidemiological, psychosocial, ethical and legal aspects. Such surveys would be integral components of national AIDS prevention and control programmes. In plenary sessions and a series of panel discussions, the participants were to:

(*a*) discuss the current trends in HIV infection among various targeted populations and groups engaging in high-risk behaviour;

(*b*) exchange information on and review the results of seroprevalence studies in Member States, and formulate advice and guidelines for the further development of such studies;

(*c*) exchange information and views on the advantages and disadvantages of various testing procedures;

(*d*) discuss the measures available to public health services for the effective containment of AIDS in Europe;

(*e*) share knowledge on the latest developments in research on the control of HIV infection and AIDS;

(*f*) recommend standard surveillance methods and approaches for use in the European Region, the research required to develop such methods, and improvements in the information support systems;

(*g*) comment on the funding requirements of and the ethical, legal and counselling considerations involved in surveillance; and

(*h*) recommend evaluation procedures, and any follow-up action that might be needed from WHO.

In addition, statements were distributed from the declaration of 13 March 1989 of the health ministers of the member states of the European Communities and the declaration of the International AIDS Society for World AIDS Day, 1 December 1988.

Overview

AIDS Notification

The participants were informed that, as of 1 March 1989, 145 countries had reported 142 000 cases of AIDS. Of these countries, 46 were in Africa, 42 in the Americas, 29 in Asia and Oceania and 28 in Europe. WHO regards this as undernotification, and estimates the actual number of people with AIDS, around the world, to be over 400 000. The Organization predicts that the figure will rise to 1.1 million by 1991. It is estimated that 5–10 million people are already infected with HIV: about 2.5 million in Africa, 2 million in the Americas, 500 000 in Europe and 100 000 in Asia and Oceania. About 80 000 children in Africa are estimated to have been infected between 1980 and 1987.

In the European Region, 31 countries had reported 19 196 cases of AIDS by 1 March 1989. This represented an 87% increase during 1988. Switzerland, France and Denmark registered the highest rates per million population (106.4, 101.7 and 70.2, respectively). These rates were rising most rapidly in France, Italy and Spain. Of the AIDS cases, 87% were found in men and 85% in the group aged 20–49 years. Based on current estimates, the cumulative total of cases diagnosed by 30 June 1990 could be 63 000.

Public Health Surveillance

Participants were brought up to date on current knowledge of retroviruses and the emerging problem of the second strain of HIV (HIV2). Although predominantly affecting parts of West Africa, it has appeared in some European countries. No effective therapy is available and the development of an effective vaccine is some years away. These facts showed the importance of health promotion programmes in preventing the spread of infection and the need for

seroprevalence surveillance studies to monitor their effectiveness. Public health surveillance was defined as the collection of information on the distribution and spread of infection that is sufficiently accurate and complete to be pertinent to the design, implementation or monitoring of prevention and control programmes and activities.

The methods of HIV testing known to be used in Europe were described. Screening could be:

— unlinked anonymous
— voluntary anonymous
— voluntary confidential
— mandatory
— compulsory.

In the majority of countries, risk or targeted groups in the population are offered voluntary anonymous or confidential screening.

When HIV prevalence is moderately increased, the prevalence revealed by anonymous testing is usually much greater than that shown by voluntary testing of the same population. A review of the literature demonstrated limited experience in Europe with unlinked anonymous HIV testing.

Unlinked Anonymous Screening

Unlinked anonymous screening was defined as the screening of blood specimens for markers of infection after the elimination (unlinking) from each specimen of all information identifying the people from whom the blood was taken.

The epidemiological objective of the public health surveillance of HIV infection is primarily to obtain information on the prevalence and incidence of the infection in selected population groups in a manner that is as free as possible of participation and selection bias. Unlinked anonymous screening eliminates or minimizes participation bias but, as it involves the use of blood collected for other purposes, the effect of selection bias remains and depends on the time, location and other details of blood collection. From an epidemiological perspective, this type of screening offers a distinct advantage for the public health surveillance of HIV infection.

The participants were reminded of the criteria to be met if unlinked anonymous screening is to be undertaken.

1. It is essential to conduct a thorough discussion of the ethics of this type of testing in the social and cultural context of the country where it is to be used. It should not be implemented without the approval of national public health authorities.

2. The specimens for screening should have been taken for other legitimate purposes. To take blood primarily or solely for unlinked anonymous screening raises serious ethical concerns. The volume of blood taken should be the minimum necessary — at most, only marginally greater than that required for the primary purpose for which it is obtained.

3. No information in addition to that normally collected for these purposes should be requested.

4. All data that could result in the identification of individuals must be removed from the specimens set aside for screening before they are tested by the laboratory.

5. Protocols for unlinked anonymous screening should be scrutinized in detail to ensure that:

— the test results cannot be traced to individuals;

— studies are designed and test methods selected to maximize the likelihood of obtaining data useful for surveillance purposes, given the estimated prevalence in the population concerned; and

— staff are trained and supervised to avoid breaches of anonymity and to adhere to the protocol.

6. Confidential or anonymous voluntary testing with counselling should be available where appropriate to populations in which unlinked anonymous screening is being undertaken. Such testing should be offered through a separate system, for people who wish to know whether they are infected with HIV.

7. The resources devoted to unlinked anonymous screening should be commensurate with its value for surveillance as one part of a comprehensive programme for the prevention and control of HIV and AIDS. The screening should not detract from other important public health objectives, including the primary purposes for which the blood specimens were obtained.

8. Health care providers taking specimens that may be sampled for unlinked anonymous screening should be aware of this potential additional use of the specimens.

HIV in the USSR

The epidemiological situation of HIV infection in the USSR and particularly the outbreak of HIV in a children's hospital in the town

of Elista were presented and thoroughly discussed. Of the more than 20 million people tested, only 176 Soviet citizens have been found to have HIV. Infection was mainly due to sexual transmission of the virus and, as in the outbreak in Elista, the use of unsterilized HIV-contaminated syringes.

HIV surveillance and the evaluation of prevention and control programmes

HIV Surveillance in Europe

Attempts to determine the prevalence of HIV in the European Region date back to the autumn of 1984, when the first tests for HIV antibody became available. Attention first focused on the primary risk groups — homosexual and bisexual men and intravenous drug users — but many other groups were subsequently surveyed.

HIV prevalence data from the European Region were assembled by the WHO collaborating centre for AIDS in Paris, and reviewed at a meeting held in February 1989. The picture emerging from the seroprevalence studies is consistent with the picture obtained from AIDS reporting. In the southern countries of the Region, the people primarily affected are intravenous drug users, while in the northern countries HIV infection first appeared in homosexual and bisexual men and later spread to intravenous drug users. There are geographical variations in all these countries, but in general the prevalence of HIV in the adult population is estimated to be below 0.1%.

Studies of Groups with High-risk Behaviour

The proportion of AIDS cases found in heterosexual intravenous drug users has increased sharply in the Region, from 1% in December 1984 to 25% in December 1988.

Of the people at special risk of HIV infection, intravenous drug users are probably the most difficult group to study, because of the nature of their lifestyle and heterogeneity of their patterns of drug use. Making contact with these people can be difficult, and the illegal nature of their habit makes them secretive and wary of authority. Differences in lifestyle and patterns of drug taking make representative sampling almost impossible. Anonymous unlinked surveillance of this group is difficult, as in general blood is not routinely

taken for other purposes. At present, seroprevalence studies of intravenous drug users are commonly undertaken on a voluntary basis. Such studies raise problems with participation bias, counselling and the ethical issues of persuading drug users to be tested. HIV seroprevalence studies of this group are undoubtedly needed:

— to make an initial assessment of seroprevalence and, if possible, to study differences in demographic characteristics between the people infected and those not infected;

— to identify trends in seroprevalence over time;

— to determine rates of seroconversion in drug-taking populations; and

— to evaluate measures taken to prevent the transmission of HIV.

From the information available to the WHO Regional Office for Europe, only very broad estimates can be made of the total numbers of drug users and of those thought to take their drugs by injection. In almost every case sample populations are composed of intravenous drug users in treatment. A study of entrants to methadone programmes in two successive years, however, gave an indication of the level of seroprevalence outside treatment groups. Four countries — Denmark, Norway, the United Kingdom and Yugoslavia — were able to provide figures for the numbers of intravenous drug users found to be HIV antibody positive by national surveillance schemes. Another useful source of data has been studies on seroprevalence among intravenous drug users in prison.

Outreach workers should try to recruit intravenous drug users who are not in treatment for prevalence studies. When fully developed and evaluated, a test using saliva rather than blood may be a helpful inducement when facilities for collecting blood are not available.

The studies of men with homosexual behaviour provide no conclusion on the average prevalence of HIV infection in this group in Europe. Representative studies are lacking and relatively few studies have been made of subgroups of the gay community with various types of sexual behaviour. More studies of male homosexuals need to be undertaken, preferably linked to studies on the demographic and psychosocial determinants of sexual behaviour.

Although prostitutes form a well defined population and generally occupy well known territories, these men and women have little motivation for participating in seroprevalence studies and obtaining a representative sample can be a difficult task. With sexual

transmission representing the major mode of HIV dissemination, more information must be obtained on HIV in prostitutes. Such populations could be used as sentinels, to provide additional information about the spread of HIV and AIDS among heterosexuals. Experience suggests, however, that female prostitutes would cooperate in such studies, particularly if health promotion and counselling services provided support. In some countries, information can be obtained on registered prostitutes from sexually transmitted disease clinics and from physicians with prostitutes as clients.

In the European Region, data on female prostitutes are available from only a few studies. In general, however, rates of HIV infection in this group remain low, although they are higher among prostitutes who are also intravenous drug users.

Monitoring HIV Infection in Populations

HIV infection should be monitored in populations for three reasons. First, the long latent period between the appearance of serological markers of HIV infection and the development of a fully recognizable clinical disease (AIDS) or AIDS-related complex, precludes waiting for case reports to assess the magnitude of the problem and select and adapt control measures. Second, information on current patterns of HIV prevalence and transmission is necessary for designing any programme to prevent or control the infection. Third, regular monitoring of HIV infection and transmission patterns will provide prompt and effective feedback to programme managers about the efficiency of their strategies. The surveillance of HIV infection also provides the basis for identifying high-risk population groups and geographic areas of high prevalence.

Objectives of HIV Surveillance

HIV surveillance should be conducted to measure and monitor the incidence, prevalence and distribution of the infection in defined population or study groups. The data collected should be used to establish baselines against which future trends can be assessed, and to compare incidence and prevalence among various population or study groups. This would allow the evaluation of the efficacy of programmes to prevent and control HIV infection. In addition, studies should be made of the relationships between HIV prevalence and:

— the behaviour of various groups in their socioeconomic and cultural contexts and their living conditions; and

— the spread of infection in newly affected areas.

HIV surveillance mechanisms

Need for Counselling

People with HIV need psychosocial support. Counselling plays a vital part in all strategies for the prevention and control of AIDS. It helps not only people who are already infected but also to prevent the further spread of HIV. More people trained in counselling skills are needed and services should be readily available.

A survey of the counselling services given before and after HIV testing in 12 European Member States concluded that counselling should ideally be provided through existing structures in the health care service; special solutions should be found only when absolutely necessary. Counselling should be available with a minimum of delay at the places in the health care system where people with HIV present themselves.

The contribution of voluntary organizations should be remembered in the planning of counselling and psychosocial support services. In addition, regular evaluation of the outcome of counselling is important.

Ethical Issues

Several possible conflicts of interest arise between the individual and society. Can society both effectively protect itself against the spread of HIV infection and preserve its basic values? A careful cost–benefit analysis — in scientific, practical, financial and ethical terms — must be made of the value of HIV seroprevalence surveys in general and each study planned. In such analyses it is important to remember the ethical implications inherent in the scientific, practical and financial aspects of surveillance, in addition to the dimension of the ethical costs and benefits to the individual and society. If human rights are to be respected, the best methods are those that accomplish the public

health objectives of preventing and controlling HIV and AIDS, and monitoring the effectiveness of the measures taken, with the least intrusion on the individual's integrity and autonomy.

When HIV seroprevalence studies are planned, implemented, monitored and evaluated, questions must be asked to determine:

— the purpose the data collected will serve

— the information needed

— the costs and benefits to society

— the advantages and disadvantages to the individual

— whether there are other ways of obtaining the information at less cost to the integrity and autonomy of the individual.

If these issues are considered, the choice of method can be defended in the face of scientific, practical, financial and ethical scrutiny.

Other Issues in Surveillance

In developing and continuing an HIV surveillance system, all the varieties of data obtainable must be collected, analysed and carefully interpreted. Further, national programmes must specify in advance the uses to which the information obtained will be put. Surveillance studies should not concentrate on the easiest populations to study, such as pregnant women and military recruits, rather than the sentinel populations such as people with sexually transmitted diseases and intravenous drug users.

The participants received copies of a draft document prepared by the WHO Global Programme on AIDS and listing the available surveillance methods. No method is ideal; countries should choose methods appropriate to their aims from the menu given in the document. In addition, a software package called EPI/INFO is readily available from the Programme; many participants stressed its usefulness in data analysis. The Programme has also developed a data base on HIV prevalence in Africa, and WHO offered to assist in the further development of a similar data base recently established by the WHO collaborating centre for AIDS in Paris.

The participants discussed the meaning of the term "the general population". If the term excludes vulnerable minorities, surveying the general population may not be useful. If the general population is viewed as the total population, however, including minorities, surveying trends in HIV infection in this population may be useful for indirectly monitoring trends in the minorities. Again, no method of obtaining data is perfect; it is important that no single method should

be relied on exclusively. This is particularly important in countries in which unlinked anonymous screening could meet legal or ethical problems.

The participants agreed that the ethical costs of the various survey methods should be widely discussed within each country before a surveillance package is introduced. There was some discussion of the implications of using unlinked anonymous surveys to study other problems, such as alcoholism in airline pilots or hepatitis B in health care workers.

As a single case definition for AIDS is now used throughout the Region, a comparable initiative was suggested: scientific and technical staff at both the national and international levels should analyse and distribute data on HIV serosurveillance. The pooling of sera could be considered to reduce the costs of large surveys where prevalence is low. It was stressed, however, that only specified laboratory screening tests should be used for pooled sera and that national HIV reference laboratories should be consulted on this point.

National policies for the prevention and control of HIV and AIDS

This topic was discussed under the following headings: programme activities and budget allocation, surveillance in the future and implications for resource allocations, assessing the effectiveness of prevention and control measures, and research. During the discussion that followed, it became apparent that there was considerable interrelationship between the topics. The recommendations that resulted are applicable to all countries irrespective of their pattern of HIV prevalence.

Resources and Coordination

The diversity of social, cultural and political traditions within the European Region precludes a definitive statement on the prevention and management of the AIDS epidemic. Nevertheless, a structured review of the policies and programmes regarded as essential to combat HIV infection provided a sound basis for assessing the progress to date. Many policies and programmes have been implemented, some before clear national policy guidelines were formulated. There are indications that the structuring and allocation of resources for such schemes have recently been improved. Better definition of the legal and administrative frameworks is still needed to delineate responsibilities and rights.

A coordinating mechanism, called a national AIDS committee, is fundamental to an effective national programme against AIDS. It should have a multidisciplinary membership (ideally involving nongovernmental organizations) and an intersectoral mandate, meet regularly and formulate policy. In some countries the coordinating mechanism is an interministerial or consultative group; such groups should meet the same criteria.

Almost all countries have established AIDS coordinating groups, with the clear objective of preventing the spread of HIV infection.

Attention must also be paid to the other two components of the epidemic: the care of people with HIV and AIDS, and the social, ethical and political reaction to the disease.

Legislation

The AIDS pandemic has undoubtedly placed great pressure on health care systems, thereby highlighting weaknesses and deficiencies in these services. Legislation and health care systems must provide the structures for a humane and effective response to the problem. There is no need or justification for the restriction of basic freedoms by such measures as closing borders, limiting access to care, tolerating discrimination or violating personel autonomy. This could constitute a greater danger to public welfare than AIDS itself.

Health care providers must serve all patients to the best of their abilities, accepting the inherent risks of health care. Institutions at all levels must provide information and facilities conducive to the safe, effective and humane treatment of all patients.

AIDS should not be considered in a category separate from other infectious diseases. Nor should it be dealt with by an isolated legislative approach. Existing laws for the prevention and control of infectious diseases should be re-examined and updated if necessary, to ensure that they can deal with the epidemic and protect the rights of the individual and the community. Traditional legislative measures on public health should be re-evaluated to assess their effectiveness and ethical acceptability in relation to AIDS. Health legislation should be used in a positive way, to promote and support health education and the distribution of information that can provide the public with the means for voluntary behavioural change. If legislation affecting the AIDS problem is to be enacted, advice should be sought from organizations working in this field.

Role of Counselling

In national programmes for the prevention and control of HIV and AIDS, counselling services should be integrated into the broader context of health promotion in general, into school curricula, and into the education of physicians, nurses, midwives, social workers and any other group involved in AIDS prevention, management and control.

Counselling contributes to the primary, secondary and tertiary prevention of HIV transmission at the personal level. It is thus important in preventing the spread of infection. Counselling on AIDS must play a fundamental role within a continuum of care. Multidisciplinary teams must provide services at the community level

and in an ethical and cost-effective manner. The evaluation of counselling techniques and outcomes is also essential, and therefore important for seroprevalence studies. Research is required on people's perceptions of infectious disease transmission in general, conceptual language, the revision of health beliefs and risk reduction models, and ways of improving communication.

Preventing the spread of HIV among intravenous drug users involves increasing the efforts to identify and attract such people into treatment facilities; here risk reduction can be encouraged as a first priority within the overa" objective of drug use control. It must be accepted that some will . t be persuaded to participate in such a scheme; outreach worket must try harder to educate them and advise on behaviour to reduce risk, such as ceasing to share drug injecting equipment, using bleach to sterilize needles and syringes, taking advantage of needle and syringe exchange schemes, and practising safer sex. The surveillance of HIV seroprevalence in drug-using populations is essential, not only to determine trends but to ascertain whether preventive efforts are effective.

Recommendations

HIV Surveillance in the European Region

1. HIV-seroprevalence studies should continue among groups with high-risk behaviour and be extended to cover populations assumed to be at low risk.

2. Unlinked anonymous screening could be considered a means of obtaining reliable data on HIV seroprevalence.

3. Member States should adopt a set of minimum requirements for the design and execution of studies, following the recent WHO proposals.

4. Sampling techniques should be employed where feasible or possible.

5. Member States should report data on HIV and AIDS to WHO. These should cover:

- the explicit aims of surveillance;
- a description of the target population by age, sex and risk behaviour (if any);
- the use of the recommended sampling procedure;
- where the data have been published elsewhere, references to the publications; and
- the measures to be taken as a result of the surveillance.

The quality of the data should be validated locally, before the information is sent to WHO or to a designated collaborating centre.

6. WHO should continue to use the WHO collaborating centre for AIDS in Paris to receive, analyse and disseminate these data, at least annually.

7. WHO and the collaborating centre in Paris should give priority to the development of a standard classification for HIV serosurveys in Europe, to improve the comparability and interpretation of data.

8. WHO and the collaborating centre in Paris are urged to continue and extend their efforts to assist Member States in designing and conducting serosurveys where necessary, and to coordinate studies in progress.

9. WHO headquarters and the Regional Office for Europe should provide the personnel and material support to strengthen the capabilities of the WHO collaborating centre for AIDS in Paris, to meet the expected demands from Member States.

HIV Surveillance Mechanisms

10. The ethical and legal issues entailed in each of the HIV serosurvey methods should be discussed in each Member State.

11. How a survey's findings will be used should be defined in advance, as part of the survey's design.

12. Voluntary testing facilities should be available in addition to and separate from seroprevalence studies.

National Programmes for the Prevention and Control of HIV and AIDS

13. National prevention and control programmes should cover four interrelated and coordinated areas:

- public health
- treatment, counselling and support services
- information and education
- research.

14. National programmes should be continuing and subject to regular evaluation.

15. The programmes should be sustainable and integrated with existing health, social and educational services.

16. The programmes should be multisectoral.

17. Each Member State should devise programmes appropriate to its needs and practices, but should also consider the requirements of travellers to and from other countries.

18. Some groups may be more difficult to reach than others because of language, cultural and educational differences, for example. National programmes should include such groups and ensure that they are protected from discrimination.

19. Studies are required to improve the knowledge of current sexual behaviour, and further studies will be necessary to detect changes.

20. Evaluation studies must be performed under conditions in which the individual's human rights are protected.

21. Linked, voluntary surveillance studies can provide valuable information on risk factors. When such studies are performed, confidentiality must be guaranteed, discrimination excluded and individual counselling provided.

22. The incidence and prevalence of sexually transmitted diseases are important markers of sexual behaviour, and Member States should ensure that there is adequate surveillance of these diseases.

23. Each Member State should also undertake appropriate national surveillance for HIV2 and human T-lymphotropic virus I (HTLV1).

24. Variations in seroprevalence trends should be carefully analysed before being attributed to prevention programmes.

25. Member States should review the allocation of their AIDS budgets, and ensure that there is adequate funding for a balanced AIDS prevention and control programme.

26. Finally, the present international cooperation in the struggle against AIDS should continue and be fostered.

Annex 1

Working papers[a]

ICP/GPA 041/6	Global review of the HIV/AIDS pandemic, by J. Mann
ICP/GPA 041/7	Epidemiological situation on AIDS in Europe, by J.-B. Brunet
ICP/GPA 041/8	HIV/AIDS situation in the USSR, by V.I. Pokrovsky
ICP/GPA 041/9	Review of current knowledge on HIV and other retroviruses, by L. Montagnier
ICP/GPA 041/10	Public health surveillance of HIV infection, by J. Chin
ICP/GPA 041/11	European data on HIV seropositivity surveys: advantages and disadvantages of various HIV surveillance strategies, by A. Gromyko
ICP/GPA 041/12	Strengths and weaknesses of the available serodiagnostic methods, by G. Biberfeld
ICP/GPA 041/13	HIV seropositivity surveillance as a basis for evaluating the efficacy of national AIDS prevention and control programmes, by M.A. Koch

[a] Copies are available from the Regional Programme on AIDS, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø.

ICP/GPA 041/14	Efficacy of sentinel surveillance for HIV seropositivity, by A. Stroobant
ICP/GPA 041/15	Anonymous unlinked HIV serosurveillance: experience in European countries, by O.N. Gill
ICP/GPA 041/16	Using mortality data to enhance HIV surveillance, by A. McCormick
ICP/GPA 041/17	Psychosocial support for HIV seropositive persons as a prerequisite for seroprevalence surveys, by B. Gredler
ICP/GPA 041/18	Ethical dilemmas in HIV seroprevalence studies, by S.-E. Ekeid
ICP/GPA 041/19	Analysis of pre- and post-test counselling services in 12 European Member States, by P. Grøn
ICP/GPA 041/20	Preliminary results of national AIDS policy study, by S. Wayling
ICP/GPA 041/21	Role of counselling in national AIDS/HIV prevention and control programmes, by B. Gredler
ICP/GPA 041/22	Programme priorities and budget allocations by L. Ayres
ICP/GPA 041/23	Prevention of HIV transmission among IVDA in the European Region, by R.G. Covell and C. Goos

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The many challenges of AIDS have resulted in a variety of policies and programmes to prevent and control HIV, and to support people living with HIV or AIDS. WHO has taken the lead in developing a foundation on which Member States can build their national programmes. The common concern is to shape the most effective responses to the epidemic, while recognizing human needs and rights.

This book, a report on a recent WHO meeting, begins with an overview of the current situation and trends in the European Region and then concentrates on HIV surveillance and its clinical, legal, ethical and economic issues. It suggests that serosurveys could provide information vital to the design, implementation and evaluation of effective policies and programmes. The report includes discussion and recommendations on the methods, problems and usefulness of testing groups at special risk and the general population, on the ethical and practical issues of HIV surveillance, and the scope and characteristics of effective national programmes.

This book is interesting and useful reading for decision-makers, health authorities, professionals in health and other sectors, and the public. It can help countries take action against AIDS.

The complete proceedings of the meeting are available from the Regional Programme on AIDS, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark

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